TEXAS DEPARTMENT OF INSURANCE
Division of Workers' Compensation - Medical Fee Dispute Resolution (MS-48)
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MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name
Kasey Kunkel, D.C.

Respondent Name
Travelers Indemnity Company

MFDR Tracking Number
M4-17-2363-01

Carrier's Austin Representative
Box Number 5

MFDR Date Received
April 7, 2017

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "99456 W5 WP MMI = $350.00
IR – W/ROM = $300.00
TTL = $650.00"

Amount in Dispute: $150.00

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "The Provider contends they are entitled to additional reimbursement of $150.00 for 99456-W5-WP. For this CPT code, the Carrier reimbursed the Provider $350.00 for the Maximum Medical Improvement evaluation per Rule 134.250(3)(C), and $150.00 for the DRE-based lumbar spine impairment rating assignment per Rule 134.250(4)(C)(ii)(I)."

Response Submitted by: Travelers

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
December 12, 2016	Designated Doctor Examination	$150.00	$150.00

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and applicable rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

1. 28 Texas Administrative Code §133.307 sets out the procedures for resolving medical fee disputes.
2. 28 Texas Administrative Code §134.250 sets out the fee guidelines for examinations to determine maximum medical improvement and impairment rating provided on or after September 1, 2016.
3. The insurance carrier reduced payment for the disputed services with the following claim adjustment codes:
   - P12 – Workers' compensation jurisdictional fee schedule adjustment.

- 309 – The charge for this procedure exceeds the fee schedule allowance.
- W3 – Additional payment made on appeal/reconsideration.
- 863 – Reimbursement is based on the applicable reimbursement fee schedule.
- 947 – Upheld no additional allowance has been recommended.

Issues

Is Kasey Kunkel, D.C. entitled to additional reimbursement?

Findings

Dr. Kunkel is seeking additional reimbursement of $150.00 for a designated doctor examination to determine maximum medical improvement (MMI) and impairment rating (IR) performed on December 12, 2016. Per 28 Texas Administrative Code §134.250(3), "The following applies for billing and reimbursement of an MMI evaluation… (C) An examining doctor, other than the treating doctor, shall bill using CPT Code 99456. Reimbursement shall be $350." The submitted documentation supports that Dr. Kunkel performed an evaluation of MMI. Therefore, the reimbursement for this examination is $350.00.

Per 28 Texas Administrative Code §134.250(4), "The following applies for billing and reimbursement of an IR evaluation … (C)(ii) The MAR for musculoskeletal body areas shall be as follows … (II) If full physical evaluation, with range of motion, is performed: (-a-) $300 for the first musculoskeletal body area…" The submitted documentation supports that Dr. Kunkel provided an impairment rating, which included a musculoskeletal body part, and performed a full physical evaluation with range of motion of the lumbar spine. Therefore, the reimbursement for this examination is $300.00.

The total reimbursement for the disputed services is $650.00. Travelers Indemnity Company reimbursed $500.00. An additional reimbursement of $150.00 is recommended.

Conclusion

For the reasons stated above, the Division finds that the requestor has established that additional reimbursement is due. As a result, the amount ordered is $150.00.

ORDER

Based on the submitted information, pursuant to Texas Labor Code Sec. 413.031 and 413.019 (if applicable), the Division has determined that the requestor is entitled to additional reimbursement for the services in dispute. The Division hereby ORDERS the respondent to remit to the requestor the amount of $150.00, plus applicable accrued interest per 28 Texas Administrative Code §134.130, due within 30 days of receipt of this Order.

Authorized Signature

	Laurie Garnes	May 5, 2017
Signature	Medical Fee Dispute Resolution Officer	Date

YOUR RIGHT TO APPEAL

Either party to this medical fee dispute has a right to seek review of this decision in accordance with 28 Texas Administrative Code §133.307, 37 *Texas Register* 3833, applicable to disputes filed on or after June 1, 2012.

A party seeking review must submit a **Request to Schedule a Benefit Review Conference to Appeal a Medical Fee Dispute Decision** (form **DWC045M**) in accordance with the instructions on the form. The request must be received by the Division within **twenty** days of your receipt of this decision. The request may be faxed, mailed or personally delivered to the Division using the contact information listed on the form or to the field office handling the claim.

The party seeking review of the MFDR decision shall deliver a copy of the request to all other parties involved in the dispute at the same time the request is filed with the Division. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** together with any other required information specified in 28 Texas Administrative Code §141.1(d).

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.